Fulton State Hospital

A Facility of the Department of Mental Health Comprehensive Psychiatric Services

Strategic Plan

Issue Statement #1: To create a culture of recovery for all individuals and staff.

Desired Outcomes: A treatment culture that values individual participation in all components of recovery: treatment planning, service delivery, hospital policies and hospital decisions.

Objectives : To increase individual ownership of recovery in treatment by enhanced participation in the planning and development processes of treatment. To train and support staff in nurturing and celebrating individual recovery.

Strategy: Integrate individuals into program and hospital decision making processes. Develop Individualized Treatment and Rehabilitation Plans and reviews that are individual centered, recovery oriented, and outcome focused with choices and participation from the individual and their supports. Develop recovery oriented training for all staff.

Issue Statement#2: To create a safer environment for staff and individuals.

Desired Outcomes: The use of safe, effective alternatives to seclusion and restraint, as well as safer ways of physically intervening in crises when unavoidable.

Objectives: Increase staff skills for non-physical interventions with a "tool box" of non-physical intervention skills. Improve Staff Support processes. Provision of meaningful post crisis debriefing for staff and individuals. Personal Safety Plans on Individualized Treatment and Rehabilitation Plans.

Strategy: Develop and implement new training materials. Revise physical techniques currently taught and identify alternative. Revise and implement changes in staff support process. Establish Personal Safety Plans with individuals and integrate them into treatment plans. Develop protocols to effectively deploy staff in order to avert crises.

Issue Statement #3: To involve program, unit, and hospital leadership in methods to review and reduce seclusion and restraint usage.

Desired Outcomes: Involvement of appropriate level of administration to assist staff with identifying strategies to reduce Seclusion/Restraint. Staff will accept Administrative involvement as a valuable tool and see this as a process to improve safety for individuals and staff.

Objective(s): Increased involvement of administrative staff resulting in fewer seclusion/restraint incidents.

Strategy: Administrative involvement introduced to staff and supported by administration. Develop a tiered system for notification that will include program leadership, unit administration, and executive leadership.

Issue Statement #4: Individuals will have a greater role in the life of the organization.

Desired Outcomes: All Program Manuals and Departmental, Unit and Hospital Policies will have evidence of individual participation in review. Increase in volunteer opportunities, outreach efforts and educational offerings by advocacy groups for individuals and in employee membership in advocacy groups.

Objective: Integrate individuals systemically into committees and work groups. Increase individual exposure to consumer role models. Encourage individual involvement in various volunteer activities and with Consumer Advocacy groups to perform outreach and educational activities involving individuals, their families and employees.

Strategy(s): Develop policy and mechanisms to ensure that all councils and standing committees have maximum individual inclusion. Develop mechanism for soliciting consumer review of relevant hospital, program and departmental policies. Hire consumers to serve in direct care, professional, administrative and support-staff roles. Develop volunteer opportunities for consumers, both within the hospital and the larger community. Introduce advocacy groups to individuals, families and staff

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and for offering select educational activities.

Issue Statement #5: Build a culture of partnership between staff and individuals, by eliminating or substantially reducing barriers between staff and individuals that contribute to a "Culture of Control and Coercion."

Desired Outcomes: Recommendations for the elimination of specific barriers. Enhanced satisfaction during Consumer Satisfaction Survey. Plan for the development of a drop-in center.

Objective: Eliminate all unnecessary structural barriers between staff and the individuals they serve.

Strategy(s): Explore all physical barriers, the need for continued use of uniforms and revise Boundary Training materials to focus on relationships built on trust and honesty, emphasizing the continued importance of appropriate boundaries between staff and individuals. Explore all policies and practices that separate consumer and staff opportunities for contributing to the community.

Issue Statement #6: Improve our Assessment of Individuals with Trauma History.

Desired Outcomes: Identify scope of the existing problem. Information supportive of such diagnoses will be reflected in the diagnoses of the individual as staff will be able to identify individuals with trauma histories or trauma specific needs. A complete training curriculum for trauma.

Objective: Appropriately diagnose all individuals with trauma histories. Integrate assessment and diagnosis of trauma history into treatment plan.

Strategy(s): Identify individuals qualifying for a diagnosis of a trauma based disorder. Improve education of individuals and staff on Trauma. Develop and implement additional training in trauma for all employees, including awareness of own trauma histories. Provide educational materials in consumer education racks and teach about Trauma in Mental Health Education Groups.

Issue Statement #7: Provide Trauma Specific Treatment, with specific attention to trauma symptom management and emotional regulation.

Desired Outcomes: A tool-kit/reference text of interventions and strategies for inclusion in the Treatment and Rehabilitation Plan. A protocol for managing egregiously traumatic events. A structure of support in group meetings, with individual meetings as needed. Inclusion of consumer speakers in Trauma training.

Objective: Address specific trauma symptoms as they arise in order to facilitate emotional regulation.

Strategy: Develop a continuum of focused Interventions/Scripts for individuals with past or current trauma events. Develop protocol for managing egregiously traumatic events during hospitalization, with specific attention.

Issue Statement #8: To reduce the use of seclusion and restraint through improved risk assessment, early identification and early intervention.

Desired Outcomes: Increased staff awareness of any individual with increased risk factor. Development of specific behavioral interventions and precautions, utilizing client involvement, that will guide staff in their behavioral responses. Development of advanced behavioral directives that will serve as specific guidelines for staff.

Objectives: Identification of physical, emotional, and cultural factors that could place an individual at increased risk should restraint have to be used with individualized early warning signs and early interventions for any consumer with a history of aggression.

Strategy: Develop an educational packet for teams that would identify at-risk individuals. Actively involve each individual in developing a Personal Safety Plan regarding what should be done to help avoid need for seclusion/restraint.

Issue Statement #9: Using Data to Inform Practice

Desired Outcomes: Facilitate availability and allow end users greater access without duplication of effort. Data that can drive decision making at ward and individual patient level. Data which can be acted upon in a timely manner.

Objective(s): Data available, accessible and timely to all stakeholders at all levels in the facility. New partnership with data guardians. New data sources to support the Safety Initiative. Development of a data sheet for gathering information on the seclusion and restraint event.

Strategy: Share data and manpower resources. Conduct regular meetings to understand current data systems, coming changes, and plans to accommodate the changes. Devise questions with staff input which would be pertinent to the seclusion and restraint process that can be rated so statistical

data can be obtained.

Ethics
Fulton State Hospital has an ethical responsibility to the individuals and community it serves. Our hospital philosophy, through our mission, vision, and values provides a consistent and ethical framework for our consumer care and business practices. To support ethical operations and fair treatment of individuals, Fulton State Hospital has and operates according to a policy of ethical behavior. The policy addresses ethical practices regarding marketing, admissions, transfers, discharge, and billing and resolution of conflicts associated with patient billing. Our policy ensures that the hospital conducts its business and consumer care practices in an honest, decent, and proper manner.

Consumers
Fulton State Hospital is a 496 bed, Medicare-Certified, Joint-Commission accredited, long-term inpatient facility. We serve primarily an adult (18 years old and older) population which has been committed to the state facility through the following admission categories: pretrial evaluation, incompetent to proceed, not guilty by reason of mental disease or defect, voluntary, adult court order, criminal sexual psychopath, Circuit Court, and Department of Corrections transfers.

The number of admissions in these classifications has remained relatively stable over the past several years. However, changes in state and federal statutes related to commitment status, and the rapidly increasing number of inmates in the Department of Corrections requiring mental health services may have a dramatic impact on the number of individuals we serve, their length of stay, the level of security we provide and the type of treatment offered.

Consumer satisfaction and input is an important element in any strategic plan. While FSH has in the past and will in the future continue to perform and analyze the results of consumer satisfaction surveys, and has assisted in the development of Consumer Councils in each of our units to allow individual input, it must be realized that the data reflected from these processes will be somewhat skewed because the majority of the individuals are involuntarily committed and in many cases receiving treatment they do not believe they need. We do take seriously the information garnered from this process and try to improve living and treatment environments based on this information.

Active Treatment
FSH provides a wide variety of treatment modalities for the indivduals served. This would include prescribing the most recently released medications for schizophrenia, depression, and substance abuse addiction such as Clozaril, Respiradone and Revia. Active treatment also includes the use of rehabilitation programs that have been publicized as having an impact on individuals previously thought of as treatment resistive. These programs include Social Learning, Boston University model, and Cognitive Behavioral Therapy. Other important programs include residential substance abuse programs, competency restoration, aggression management, work skills programs and a transitional housing program (Group Homes).

The recognition that these programs and medications have had a dramatic effect on the individuals we serve is important. In the future more medications with higher level efficacy and fewer side effects will become available; however, we are finding the cost of these medications may create barriers to their use or require the reduction in other service areas to save funds to purchase the new medications. While in the fiscal years of 1996 and 1997 the legislature has been very responsible in funding additional revenues for the purchase of the new medications, continuation of increased funding is dependent on the economic health of the state. Also, to operate high-quality programs in psychosocial rehabilitation requires expertise in the specialty program areas. This requires FSH to search out and retain the highest quality clinicians available.

Services Provided
FSH has a long history of providing care to individuals with mental illness dating back to the days when most state psychiatric facilities were fully self contained. These facilities were able to provide for their individuals any service possible without going to the community for support. Over the years many of these services have been discontinued, such as the acute hospital and dairy farm. FSH still provides many services, i.e., laundry, laboratory, environmental services, and maintenance to name a few. These services must operate economically and efficiently as more pressure is brought onto the hospital due to limited financial resources and the challenges of managed care.

Physical Plant
An assessment of the FSH physical plant reveals that most of the structures housing clients and staff are old and deteriorating. Functional buildings (approximately 40) date from 1860 to the most recent addition to the Biggs building which was completed in 1988. Our consumers currently reside in Biggs, original building 1938; first addition, 1968; second addition, 1988; Guhleman, original building, 1952; Adult Psychiatric Services, original building, 1952; and Hearnes Complex, original building, 1970. The Hearnes Complex was originally built for children and adolescents. Most of these buildings are requiring capital individual population, the physical separation between support services, administration and the individual care areas is too great. Ground crews must currently maintain 96 acres of land.

While over the past several years over 800 acres have been transferred to other state agencies and municipalities or sold, the need still exists to reduce the size of the campus, consolidate some support and administrative functions closer to the individual care areas, and upgrade individual living areas to a more therapeutic environment.

Human Resources

Our most important resource is our staff. Unlike acute general hospitals where a large amount of money is tied up in high-technology equipment, psychiatric facilities are bound only by the competence, training, education, and expertise of the staff providing care and support services to the individual. FSH has attempted over the past 10 years to recruit the highest quality medical and professional staff available within the United States. We have been successful in recruiting much-needed psychiatrists by supporting adjustments in pay scales to be competitive. FSH is not currently realizing difficulty in recruiting other disciplines. It is anticipated that recruitment of most disciplines over the next several years should not be problematic. The reason for this is the movement toward Managed Care throughout the United States. This movement is creating a surplus of care providers and many of these providers are seeking state employment due to its more stable nature.

One serious area of concern is in the classification of Forensic Rehabilitation Specialists. For the first time in the past 10 years FSH has had to advertise for applicants for these positions. This is partly due to the high level of job availability within the Mid-Missouri area and partly due to the low entry-level salaries of these positions. These positions have in past been predominantly filled by males; however, now there are a majority of female applicants. This situation is also creating a problem for staffing patterns, in that as the number of female aides increase, we have more problems in providing for the privacy of our predominantly male client population. However, the quality of staff in these positions cannot be underestimated. Creative and innovative hiring and interviewing processes have been developed, such as peer selection, to improve the quality of those hired.

Retaining highly sought after and trained staff is of paramount importance. Having to constantly recruit and retrain staff is not economically feasible. Retaining staff requires a dedication by leadership to listen to employee suggestions, to provide appropriate training, and to determine the level of employees satisfaction with their work and work environment.

Changing Environment

In the last several years, the health care environment has changed significantly. The emergence of Managed Care organizations and the replacement of typical Medicaid funding streams have everyone who works in the health care field questioning the future. These dramatic changes effect the public sector as well as the private sector. In the long-term state psychiatric setting, the impact of these changes is less certain; however, these changes will have an impact.

The political and socioeconomic environment is also undergoing significant change. There is a dramatic movement toward a more-conservative approach in dealing with social issues such as crime and welfare. These shifts will have an impact on the care provided as well as the clients served. Changes in state statutes will make commitment to state mental health facilities easier, while other law changes will make release more difficult. The increasing numbers of inmates in the Department of Corrections is increasing the need for mental health and substance abuse services. Courts are being allowed to certify youths as adults at younger ages. The need for more secure facilities for those individuals who commit violent offenses and are diagnosed with mental retardation or another developmental disability is growing. Each of these issues must be considered as we develop our plans for the future.

Public Safety

As vital as our role is in providing treatment for mental illnesses, equally important is our responsibility to provide for public safety. Built into every treatment program must be a component to appropriately and adequately measure an individuals' ability to understand the consequences of their actions and behaviors. FSH clinical staff must attempt to ensure through careful assessment of each individual's current behavior that moving the individual to a less-restrictive setting places no perceived or real danger on anyone, especially the community.

Without close attention to public safety issues, the hospital's ability to provide secure environments for treatment will be jeopardized or impaired. This impairment may result in the inappropriate shifting of mentally ill individuals to other state agencies, resulting in potentially increased cost to the state and a further reduction of public safety.

Community Relations

Individuals who have mental illnesses and reside in state institutions can and do suffer from a dual "stigma." The stigma of the mental illness and the additional stigma of being in a state institution.

To deal with the stigma of mental illness community education is crucial. This education must take place in our schools and service organizations. It must include community leadership, students and teachers, law enforcement, judiciary, and media. This education must be ongoing, up-to-date, and from all levels of individuals dealing with mental illness (individuals, family, professionals, and

administration).

The stigma of the state institution can be as difficult to deal with as the stigma of mental illness. While the stigma of mental illness is undeserved and thrust upon individuals who are suffering from a disease like any physical ailment, the stigma of the institution comes from many years of poor environments, a lack of active treatment and overcrowded facilities. Again, it is crucial to educate all individuals to the significant changes being made in long-term-care facilities as well as the advances in medications, new treatment programs, new diagnostic technology, and better trained professionals. The past cannot and should not be forgotten, but there must be education with an emphasis on the present and the future.
